



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

MILLENNIUM CHIROPRACTIC

**Respondent Name**

PROTECTIVE INSURANCE CO

**MFDR Tracking Number**

M4-14-3365-01

**Carrier's Austin Representative**

Box Number 17

**MFDR Date Received**

JULY 10, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Millennium Chiropractic is requesting Medical Dispute Resolution per Rule §133.307 for the above dates of service, for which we have received neither payment nor EOB."

**Amount in Dispute:** \$400.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The respondent did not submit a response to this request for medical fee dispute resolution.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 2013 October 21, 2013	CPT Code 90834 Psychotherapy, 45 minutes with patient and/or family member	\$200.00 X 2 = \$400.00	\$263.50

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. Neither party to the dispute submitted copies of explanation of benefits.
4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on July 21, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

## **Issues**

1. Is the requestor entitled to reimbursement?

## **Findings**

28 Texas Administrative Code §133.307(c)(2)(K) requires the requestor to submit "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." The requestor submitted convincing documentation that they requested copies of EOBs from the respondent. Since payment was not issued for the disputed services, and the basis for the denial of payment was not submitted for consideration in this dispute, the disputed services will be reviewed per applicable Division fee guideline.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service is 55.3.

The Medicare Conversion Factor is 34.023

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75061 in Irving, Texas. Per Medicare the provider is reimbursed using the locality of Dallas, Texas.

The Medicare Participating amount for code 90834 is \$81.06.

Using the above formula, the Division finds the MAR is \$131.75. the respondent paid \$0.00. As a result, the requestor is due \$131.75 X 2 dates = \$263.50.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$263.50.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$263.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

## **Authorized Signature**

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Signature

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Medical Fee Dispute Resolution Officer

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08/28/2014  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**